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ABSTRACT

Provided is a computer summary of the ratings and prescriptive suggestions on the Adaptive Behavior Checklist (ABCL) for a 5-year-old severely retarded, physically handicapped institutionalized boy. The ABCL is explained to measure basic (general motor and sensory development), primary (conceptual and language development), and secondary (social interaction and responsibility) functions. Eleven computer generated prescriptive recommendations are listed, including recommendations for programs designed to improve visual-motor performance and personal cleanliness skills. A statistical summary of the child's ratings is provided with a proration in cases where motoric or sensory limitations may mask true potential. The printout concludes with a categorization of item scores illustrating the child's strengths and weaknesses. (CL)

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THE ADAPTIVE BEHAVIOR CHECKLIST: DEVELOPMENT AND CURRENT APPLICATIONS

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The criteria for a well grounded diagnosis of mental retardation are two-fold: measured intelligence and social adaptive behavior (Mercer, 1973; Heber, 1961). The latter criterion -- social adaptive behavior, lead to the development of the Adaptive Behavior Checklist (ABCL), currently a "homegrown" version of the AAMD's ABS.

The first ABCL was primarily used to assist with residential placements in a large state supported institution for the mentally retarded (Elliot, 1969). The Checlist was patterned on the Parsons Training School Checklist, however, the ABCL was modified by form and content so that it could be more easily administered by direct care personnel. Relatedly, the initial and subsequent versions of the ABCL were specifically designed so that results could be computerized and statistically treated. The intent here was to minimize the subjectivity of anecdotal evidence and maximize the objectivity of scoring, interpretation, and comparison over time.

Later, the ABCL was used to evaluate resident progress in a Health And Rehabilitative Services Hospital Improvement

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Project (Cortazzo and Allen, 1971; Allen and Schwartz, 1973; Cortazzo and Foshee, 1970; Cortazzo, Schwartz, and Allen, 1972; Schwartz and Allen, 1974). During this period concurrent and factorial validity coefficients were established as well as the basic design and format of the current checklist (Allen, Cortazzo, and Adamo, 1970; Schwartz, Allen, and Cortazzo, 1974). Although the original versions of the ABCL consisted of 72 items, the current checklist consists of 60 items, each with a behavioral statement followed by three alternatives. The individual rating the client is required to read the statement and check one of three descriptions best fitting the client's behavior or activity with regard to the statement. For example:

1. EATING: Select the <u>one statement</u> that best describes the persons ability to eat.

   ___3. Able to eat independently.

   ___2. Able to eat with some help.

   ___1. Must be fed.

Thus, points are awarded relative to the rater's impression of the client's eating skill -- 3, 2, or 1.

For all items a score of 3 most connotates the best adjustment and 1 the lowest adjustment. Items cumulate to yield a total score and three subscores as follows:

Basic Functions -- Assesses direct care competencies and general motor and sensory development.

Primary Functions -- Assesses varying aspects of conceptual and language development.

Secondary Functions -- Evaluates client competencies for coping with responsibilities and socialization demands in daily living.

Finally, while it is important, from an administrative point of view, to evaluate a client's Basic, Primary, Secondary, and Total ABCL raw scores, it is equally, if not more, important to do something with the obtained information. That is, given the potential administrative uses of the ABCL, the issue becomes: How else can the Checklist be used so that the emphasis is not on raw "scores" but on strengths and weaknesses of individuals? Relatedly, how can defined strengths be utilized to lessen the weaknesses? In this way, the labeling processes become more meaningful. Moreover, the question no longer is soley: What is this person's I.Q., but: What can be done in view of the ratee's abilities and deficiencies in coping with the activities of daily living?

During this period in the development of the ABCL, inter-rater reliability data was collected and found to be generally

acceptable, i.e., Basic r = .86 Primary r = .88, Secondary r = .91, and Total r = .94 (Levine, Allen, and Ferris, 1974), the checklist was normed so that raw scores could be transformed to percentile rankings and Adaptability Quotients, an empirically based "cookbook" was developed so that users of the checklist could manually and mechanically manipulate ratings to yield generic program suggestions, and a computer format was developed to provide an inexpensive means for generating general program needs as well as specific ABCL strengths and weaknesses (Allen, Alker, Levine, and Loeffler, 1975; Allen, Loeffler, Levine, and Alker, 1976).

The following is an abbreviated computer illustration of the ratings and prescriptive suggestions for an institutionalized severely retarded boy (C.A.: 5 Years, 10 Months). The initial parts of the report give a heading, the name and address of the individual for whom the report was prepared, and usual demographic data, i.e., name, birthdate, chronological age, sex, and date of report.

The second part of the report is a standard introductory paragraph which reads as follows:

INTRODUCTION

The Adaptive Behavior Checklist (ABCL) was administered to help evaluate the client's adaptive competencies in terms of the activities of daily living. The prescriptive

program suggestions as well as statements of strengths and/or weaknesses which follow can be incorporated into this person's program plan to help ameliorate the defined deficiencies.

Next, sensory and motor handicapps, if present, which qualify the client's overall rating are indicated. For example:

QUALIFICATIONS CONCERNING THE DATA

Although the ABCL Checklist was standardized on a population which included individuals with sensory and motor handicaps of varying degrees, the following should be kept in mind while reviewing the results for this client:

1. The use of hands and/or arms is severely or completely impaired -

2. The use of legs and feet is severely and/or completely impaired -

In the third section of the report general prescriptive program suggestions are given. These suggestions enable teachers, cottage parents, and others to design specific curricula and/or correlate the prescription to an existing program, i.e., The Behavioral Characteristics Progression (BCP). The computer program will, given the appropriate condition, generate over thirty (30)

prescriptive program statements. The following eleven were generated for the 5 Year, and 10 Months old boy presented here:

PRESCRIPTIVE RECOMMENDATIONS

1. Consultation with appropriate medical authorities for determination of possible physical therapy, if warranted.

2. Programs designed to improve visual-motor performance, especially related to deliberateness and accuracy of movements.

3. Program designed to improve skills and habits related to self-feeding. In view of the apparent limitations in the client's use of upper extremities, achievement of proficient eating skills may not be attainable. Because of this, training emphasis should not be restricted to the actual performance of the related motoric functions but attention should also be devoted to possible modifications or alterations of routine equipment which may be necessary to bring about a reduction of the client's reliance on outside sources.

4. Programs aimed at teaching skills related to personal cleanliness. Although the client has limitations in the use of both upper and lower extremities, it may still be possible to custom some training programs along with

physical modifications of the environment so as to upgrade the client's ability to perform at least some of these functions (washing, toileting) independently. Specific suggestions would have to be made on the basis of a detailed analysis of this client's specific strengths.

5. Programs designed to teach skills related to dressing and undressing, putting on and removing shoes, and tying and untying shoelaces. Depending upon the severity of this client's physical limitations, special attention may be required in the selection and possible alteration of clothing in order to enhance the client's ability to carry out the related activities.

6. Where appropriate, continued emphasis on good oral hygiene including applying tooth paste and brushing teeth.

7. Behavioral program focusing on the acquisition of adequate attending behaviors.

8. Behavioral program aimed a decreasing reliance on step-by-step direction and/or guidance.

9. A language evaluation to include behavioral programming and speech therapy, if indicated.

10. Classroom and/or related activities to teach time relationships.

11. Attention directed at the attainment of socialization skills: i.e., selflessness, cooperativeness, consideration toward others, interaction with others, and participation in group activities.

Next, the computer gives a statistical summary of the client's ratings as well as a proration of these scores in cases where physical/sensory limitations mask "true" potential. The summary data which follows seems self explanatory.

STATISTICAL SUMMARY

	AQ	% Rank
Basic	77	07
Primary	Omitted	
Secondary	Omitted	
Total	Omitted	

When compared with institutionalized mentally retarded persons of comparable CA, this client's ABCL ratings earned the above Adaptability Quotients (Mean = 100, S.D. = 15) and Percentile Ranks:

Because this client has some physical limitations of a

severe nature, items relating directly to these handicaps were removed from the above calculations and the remaining items prorated. Although not statistically appropriate, this was done in order to provide some indication of potential abilities which may be "masked" by the sensory-motor handicap. In this instance, there were some differences observed which appear significant. Compare the results of the "standard" table above with the results in the "prorated" table below.

	AQ	% Rank
Basic	94	35
Primary	Omitted	
Secondary	Omitted	
Total	Omitted	

Finally, the computer categorizes item ratings -- 3, 2, or 1. For the sake of brevity, only the categorization of Basic Functions is presented. Primary and Secondary Function items would, however, be categorized in the same format.

CATEGORIZATION OF ITEM SCORES

BASIC FUNCTIONS

The rating of the client at this level of functioning indicates the following behavioral deficiencies (item rating = 1):

Must be fed-

Uses fingers in eating-

Does not drink from a cup or glass unassisted-

Is unable to care for self at the commode; i.e., has to be put on the toilet seat, wiped, and washed-

Is unable to wash own hands and face-

Does not cooperate in taking bath or shower-

Is unable to brush own teeth-

Is unable to care for own grooming needs; i.e., unkempt, sloopy about grooming-

Does not dress self without assistance-

Does not undress self without assistance-

Does not remove own shoes without assistance-

Is completely dependent on others in the execution of own personal custodial functions-

Cannot walk without some kind of support or help-

Has poor posture when walking sitting, or standing-

Seems to have no controlled movements when performing chores, dressing, or other activities of daily living-

The rating of the client at this level of functioning indicates there is only moderate adjustment (that is, the client needs improvement) in the following behaviors (item rating = 2):

Chews and swallows food but is not a neat eater-

Occasionally has toilet accidents during the day-

Is neat and clean but only with supervision-

The rating of the client at this level of functioning indicates the "highest" performance possible in terms of the ABCL criteria (item rating = 3):

Clothes are neat, clean, and worn appropriately-

In conclusion, the ABCL, a simplified version of the AAMD's Adaptive Behavior Scale, is being used to evaluate client progress as well as generate suggestions for remediation of defined adaptive behavioral weaknesses. The computer printout presented in this paper provides professional and paraprofessional personnel with a means of considering remedial programming. Moreover, relevant persons can easily define program priorities, write curricula around needs, and coordinate training activities.

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